

600 PROPERTY

600 Introduction -- The purpose of this regulation is to limit increases in property costs to the inflation factor allowed in payment rates.

630 Property Factors -- Due to the wide variations in property costs and the financial commitments of providers, a portion of the March 27, 1981, property costs are recognized in addition to the base rate. The variation in property costs is recognized in two ways. First, based on the property costs on March 27, 1981 as incorporated into the July 1, 1981 rates. Second, new construction as defined in Sections 631, 632 and 633. Except for new construction, the rate differentials for FY 1994 and subsequent years are the same as the rate differential established on July 1, 1991, when rates were rebased and additional property was added to the base rate. There have been no increases for buying, selling, refinancing, new leases or lease escalation clauses since March 27, 1981. Rather increases in property costs are recognized by inflating the base rate each year. The inflation index is described in Section 900 and is the basis for negotiating the annual inflation adjustments to nursing facility rates. Therefore, the State does not adopt the Medicare approach of recapturing depreciation.

631 Exception for Property Differential -- When a nursing facility operated by a State or local government is sold, a property differential will be available for meeting life safety requirements that were previously waived by the State. The differential is based on the annual depreciation calculated for the remodeling. Such depreciation will be determined in accordance with the Provider Reimbursement Manual HCFA- Pub. 15-1. In calculating a per diem cost, a 90% occupancy factor will be used. The property differential will be added to the rate in the month following submission of invoices and other requested records to support the expenditure for such property improvements.

632 New Construction Defined -- New construction is limited to either a new building or a new wing to an existing building. It does not include modifying or refurbishing an existing structure.

7/1/94

T.N. # 95-12

Supersedes T.N. # 93-28

Approval Date 01/17/96

Effective Date 07/02/95

633 New Construction Property Differential -- The property differential for new construction and related property costs will be the lesser of:

1. Actual property costs in excess of the property cost included in the base rate. The property cost in the base rate is calculated at \$8.95 per day for the period beginning July 1, 1995.
2. The simple average property differential of all nursing facilities that have a property differential. Once established, the differential does not change.

640 Return on Equity -- To provide recognition for invested capital, return on equity is recognized in the calculation of the rate differential effective July 1, 1981. Subsequent changes to return on equity do not affect the rate differential. HCFA- Pub. 15-1 is used to determine who qualifies for return on equity and to establish methodology for its calculation. Return on equity is to be determined by determining the appropriate amount to be included in the March 27, 1981, rates for qualifying nursing facilities and is carried forward as part of the rate differential. This is the same concept as the property calculation. Future transactions will not change return on equity.

T.N. # <u>95-12</u>	Supersedes T.N. # <u>93-28</u>
Approval Date <u>01/17/96</u>	Effective Date <u>07/02/95</u>

700 PAYMENT TO PROVIDERS

710 Introduction -- Payments for routine nursing facility services will be made monthly. These payments will be based on the established rate.

720 Withholding Payments -- In order to assure compliance with selected policy and to assure collection of outstanding obligations, the State may withhold payment for the following reasons:

1. Shortages in patient trust accounts -- Upon written notification that an examination of a patient trust fund account revealed an irreconcilable shortage, the facility must make a cash deposit in the full amount of the shortage within 10 days of notification. Within 30 days of such notification, documentary evidence must be presented to the Division of Health Care Financing attesting to this deposit. Failure to comply with this requirement will result in the withholding of the Title XIX payments. The cash transaction to transfer cash to the patient's account is not an allowable cost.
2. Failure to submit timely FCPs -- Reporting period requirements are specified in Section 332 titled "Reporting." If the provider fails to meet these requirements, the State may withhold payment until such time as an acceptable FCP is filed. FCPs must be complete before they are considered filed.
3. Liabilities to the State -- When the State has established an overpayment, payments to the provider may be withheld. However, if the provider is an ongoing operation and if the provider can demonstrate serious cash flow problems, the State may accept a repayment schedule signed by the provider. Normally, this repayment schedule should not exceed 90 days. For ongoing operations, the State will provide 30-day notification before holding payments. This 30-day period is to give the provider time to appeal the appropriateness of the overpayment determination. The State may waive the 30-day notification period if there is cause to believe the delay will unduly jeopardize the collection.

T.N. # 95-12Supersedes T.N. # 93-28Approval Date 01/17/96Effective Date 07/02/95

730 Limitations on Payment -- No payment rate or other settlements will exceed the facility's charges to the general public for the reporting year. In applying this limitation, the State will use the regulations established by the Medicare program, including HCFA-Pub. 15-1. The purpose of this limitation is to assure that the Medicaid program does not pay more than the general public for health care services. Providers should not use the Medicaid rate as a basis for justifying rate increases to the general public. Rather, they should use the private market forces to limit the Medicaid payment. Payments will not exceed the upper limit for specific services as defined by 42 CFR 447.253. The comparison of the Medicaid and the private rates will be made in the aggregate for all patients for a twelve month period with one exception. To give providers an opportunity to give advanced notice to private patients, the period July 1, 1995 through July 31, 1995 is excluded from the comparison.

7/1/95

T.N. #	<u>95-12</u>	Supersedes T.N. #	<u>93-22 94-021</u>
Approval Date	<u>01/17/96</u>	Effective Date	<u>07/02/95</u>

800 APPEALS

810 Introduction -- The State recognizes the need for a provider appeals procedure to provide some assurance of fair and equitable treatment. It is intended that this procedure will resolve many of the reimbursement disagreements before formal lawsuits are initiated. The appeals process involves a quasi-judicial forum for hearing grievances.

820 Filing Procedures -- The following procedures apply:

- The appeal must identify a specific audit adjustment or rate calculation.
- The appeal must include reference to specific policies and regulations.
- The appeal must be made within 30 days from the date of notification of final audit settlement or a revised payment rate.
- The appeal must include copies of pertinent documents such as payroll records, invoices, etc.

830 Purpose of Appeals -- The appeal procedure is intended to allow individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as the agency determines appropriate rates.

T.N. # <u>95-12</u>	Supersedes T.N. # <u>93-28</u>
Approval Date <u>01/17/96</u>	Effective Date <u>07/02/95</u>

900 RATE SETTING FOR NFs

900 INFORMATION

Rate setting is completed by the Division of Health Care Financing (DHCF). Cost and utilization data is required from facility cost profiles. Rate adjustments incorporate the method of determining inflation factors referenced in the KMG Main Hurdman Study of the Utah Nursing Home Inflation Index. This study uses the federal HCFA market basket groups adopted for Medicare. The weight given to each group is based on the facility cost profiles submitted to the Utah Medicaid program.

920 RATE SETTING

On July 1, 1993, the State of Utah adopted a blended per diem rate for each facility. This methodology continues for FY 1999 with minor modifications. The rate consists of three categories: (1) a flat rate, (2) a property differential, and (3) a nursing cost per diem.

921 FLAT RATE

The flat rate is paid to all nursing facilities for all Medicaid patients. The flat rate category is increased annually for inflation. For the year beginning July 1, 1998, this portion of the rate covers: (1) general and administrative (excluding salaries for medical records), (2) property and related expenses (net of differential), (3) plant operation and maintenance, (4) dietary (including dietary supplements), (5) laundry and linen, (6) housekeeping, (7) nursing cost center 07 except for lines 1-4, and (8) recreational activities. For the period July 1, 1998 through June 30, 1999, the flat rate component is \$44.70. The nursing component of the rate is defined in Section 923.

922 PROPERTY DIFFERENTIAL

The property differential category was established on July 1, 1991, and has not changed unless there is new construction. The property differential represents about 5% of the property costs and is described in Section 600. The property differential is part of the facility specific portion of the rate.

923 NURSING

The Fiscal Year 1999 nursing cost component of the rate is based on cost center 07 lines 1-4 of the Calendar Year 1997 cost report. When ownership changes during the reporting period, the State may approve a partial year for rate setting purposes. The nursing salaries and benefits are inflated by 4.5% and divided by patient days for each facility to calculate the "facility" specific portion of the rate. Nursing costs are limited to a ceiling that is calculated at 120% of the median of participating freestanding NFs. the nursing component is combined with the property differential, and in some instances an incentive payment, to calculate the facility specific portion of the rate. Facilities with nursing costs below the "nursing ceiling" qualify for the incentive. The incentive is calculated at 25% of the difference between the actual nursing costs and the ceiling, not to exceed \$2.00 per day.

T.N. No. 98-011
Supersedes
T.N. No. 97-010

Approval Date 03/23/99

Effective Date 10/01/98

T.N. # _____

Supersedes T.N. # _____

Approval Date _____

Effective Date _____

ATTACHMENT 4.19D

Page 16

924 Exceptions -- The reported nursing costs may not be representative of the level of nursing care. For example, a facility may have been operating with nursing staff for intermediate care patients and then change their license and operations to serve skilled patients. In this instance, the facility may negotiate nursing costs based on more current nursing cost experience.

925 SPECIALIZED REHABILITATION SERVICES (SRS) -- An amount is added to the facility rate that pertains to approved patients. Because the SRS rate (see Section 1910) is paid in addition of the facility specific rate, the resulting revenue is off-set against the nursing costs on the FCP. This adjustment is needed after the first year to prevent duplicate payments.

940 OBRA Waiver Adjustments -- Nursing facilities that are not able to recruit a sufficient number of registered nurses are allowed a waiver on staffing requirements. The rate is adjusted for the lower wages paid for qualified substitutes. The rate reduction is calculated by taking the difference between the RN hourly wage and the substitute employee hourly wage times the hours waived. A statewide survey of RN, LPN and nurse aide wages is used to establish the hourly wages used in the computation. The reduced wage is factored into the average per diem rate paid to the nursing facility.

95-012
Transmittal No. _____
Date Approved 01/17/96
Effective Date 07/02/95
Supersedes Transmittal 94-021

7/1/95

1000 SPECIAL RATES INTENSIVE SKILLED

1010 Introduction -- The objective of this section of the State Plan is to provide incentives for nursing facilities to admit high cost patients from hospitals. Typically these patients are ventilator dependent or have a tracheotomy. Even though the rate paid to the nursing facility is much higher than the NF rate, it is much lower than the hospital rate.

1020 Rate Determination -- Each qualifying patient will have a contract rate which is determined by negotiations between the State and the nursing facility. The rate will consider specialized equipment and supplies as well as specialized care, including special rehabilitative needs. The rate will be in effect for a period specified in the contract.

1030 Qualifying Patients -- To qualify for a special contract rate, the patient must meet the criteria of the intensive skilled level of care. Prior approval is required.

T.N. #	<u>95-12</u>	Supersedes T.N. #	<u>99-28</u>
Approval Date	<u>01/17/96</u>	Effective Date	<u>07/02/95</u>

1100 ICF/MR FACILITIES

1101 Introduction -- This Section deals with two types of ICF/MR providers -- community providers and the State Development Center.

1110 Background -- As a result of the active treatment requirements imposed by federal regulations, special consideration is given to payment rates for institutions for the mentally retarded. A specific all-inclusive flat rate is negotiated each year for the patients in each facility with the exception of the State Developmental Center (formerly the Utah State Training School). A single per diem rate is paid for all patients in the facility. The rate covers all service normally provided by ICF/MR facilities. These services are discussed in more detail in Section 400. In addition to Section 400, the following additional clarification is provided:

1. Psychological testing and evaluation, as well as brain stem tests, are covered in the flat rate.
2. Day treatment services are incorporated into the flat rate. These services may vary depending on the needs of the patients.
3. Transportation to day treatment centers is included in the ICF/MR flat rate.

1112 Incorporation of Other Rules -- The reimbursement methodology for ICF/MR community providers incorporates sections 100 through 800 of Attachment 4.19-D to the State Medicaid Plan.

In addition, the Facilities Cost Profile cost report is adopted with the following clarifications and/or modifications: 1) The per diem cost is based on the composite ICF/MR-1, ICF/MR-2 and ICF/MR-3 days and costs; 2) Cost center 01 account 05 (Employee taxes or benefits) is either direct cost or allocated based on direct salary and wage expenditures; 3) Return on equity is calculated and reported using Medicare regulations; and 4) Cost centers 07 and 08 are expanded to identify active treatment costs including physical therapy, occupational therapy, audiology, psychologists, teachers, inservice and habilitation aids.

1131 Clarification Requests -- Some provisions of the new reimbursement system may require clarification. Written requests may be submitted for more detailed explanation. Further, the State may clarify provision of the State Plan through provider bulletins and provider manual revisions.

T.N. #	<u>95-012</u>	Supersedes T.N. #	<u>93-28</u>
Approval Date	<u>01/17/96</u>	Effective Date	<u>07/02/95</u>

1100 ICF/MR FACILITIES (Continued)

1114 ALLOWABLE COSTS

HCFA-Publication 15-1 Medicare interpretations will be used to define "allowable costs" unless otherwise specified by the State Medicaid Plan.

1115 NEW OWNERS

In the event an ICF/MR facility is sold or leased to a new operator, the new operator will be jointly liable for any retroactive cost settlements. The State reserves the right to withhold retroactive cost settlements from current payments.

1190 ICF/MR PUBLIC INSTITUTION

The ICF/MR public institution (Utah State Developmental Center) is to be reimbursed retrospectively. This institution stands alone as a special provider of services. The size and characteristics of this facility require an independent categorization. The needs for this categorization include:

1. Its actual costs are not stated on a basis suitable for comparison with other ICF/MRs.
2. It is approximately seven times larger than any other ICF/MR and, therefore, comparison between it and facilities which range in size from 43 to 103 beds is questionable.
3. The majority of the patients are profoundly impaired. They require more specialized and intensive services than ICF/MR patients in community facilities.

The treatment of the ICF/MR public institution in a separate category was recommended by Lewin and Associates, a private consulting firm.

In general, retrospective reimbursement uses an average per diem cost approach. Allowable costs are divided by patient days to determine the cost per patient day. Costs are reported on the facility cost profile (FCP). HCFA Provider Reimbursement Manual (HCFA-Pub. 15-1) is used to define allowable costs for FCP reporting purposes unless otherwise specified. One exception to the Provider Reimbursement Manual is the asset capitalization policy. This exception permits the ICF/MR public institution to only capitalize those assets costing more than \$5,000.

8-12-97

T.N. # 97-011Approval Date 06/02/98Supersedes T.N. # 95-012Effective Date 08/02/97